Family Medicine Updates

AFMRD Association of Family Medicine Residency Directors

From the Association of Family Medicine Residency Directors

Ann Fam Med 2022;20:182-185. https://doi.org/10.1370/afm.2779

FROM AFMRD: WHO TO GO TO FOR WHAT: THE ABFM OR THE ACGME

The "alphabet soup" of oversight organizations in family medicine residency education can be overwhelming for program leadership new to their role. Given the recent growth in the number of family medicine residency programs, and that program leadership turnover is high (one study found that family medicine residency program directors stay in their role for a median of 4.5 years),[1] the learning curve can be steep for figuring out who you are accountable to on behalf of your learners, and for what. In this article, we will clarify the roles of 2 of the principal organizations family medicine program directors are accountable to: The American Board of Family Medicine (ABFM) and the Accreditation Council for Graduate Medical Education (ACGME). ABFM and ACGME work closely to ensure that resident physicians are well-prepared to become independent practitioners of family medicine upon the completion of their training.

ABFM

ABFM is one of the 24 boards that make up the American Board of Medical Specialties. "ABFM's mission is to improve the health of the public through certification… training standards… research… leadership development… collaboration."[1] Training standards prepare resident physicians for the Family Medicine Certification process and include completion of knowledge self-assessment exercises and performance improvement activities in addition to completion of an accredited residency training program. Accredited training programs include 3-year American Osteopathic Association (AOA)-Accredited Family Medicine Residency Training Programs, or an AOA program that has received ACGME accreditation or pre-accreditation, or an ACGME-accredited program. Successful passage of a Board Certification Exam, which is typically completed toward the end of the PGY-3 year or after completion of training, is also a requirement for Board Certification.

Program directors and leadership must ensure that the following requirements are met in order for a trainee to be eligible for Board Certification:

- Completion of full 36 calendar months of residency training, which includes 12 months in each of the PGY-1, PGY-2 and PGY-3 year, with the last 2 years of training having been completed at the same residency program
- Each year of residency must include a minimum of 40 weeks of continuity clinic experience (exceptions allowed if program has received a waiver of this requirement)
- Residents must complete a minimum of 1,650 in-person patient encounters in the continuity practice site
- At the completion of residency training, program director must verify that the graduate has met all requirements and is ready for autonomous practice

The new ABFM Family Leave Policy states that a resident can take up to 12 weeks away from the program within a given academic year without requiring an extension of training, with up to 8 weeks attributable to family leave, and up to 4 weeks for other leave as allowed by the program, *as long as the resident has at least 40 weeks of formal training in the year in which they take family leave*. A resident may take up to a maximum of 20 weeks of leave over the 3 years of residency without requiring an extension of training. This maximum allowable time away from training includes vacation time and other institutional allowances. If more than 20 weeks leave were taken over the 3 years of residency, an extension of the resident's training will be necessary to cover the duration of time that the individual was away from the program in excess of 20 weeks.

ACGME

ACGME "accredits Sponsoring Institutions and residency and fellowship programs, confers recognition on additional program formats or components, and dedicates resources to initiatives addressing areas of import in graduate medical education." In addition to the common program requirements that apply to all residency programs accredited by ACGME, the ACGME Review Committee for Family Medicine (ACGME FM-RC) proposes specialty-specific requirements that must be met in order to maintain accreditation as a residency program.

The ACGME Family Medicine accreditation requirements are reviewed and updated annually, and include expectations regarding sponsoring institutions, participating clinical practice sites, resources that should be available to residents, faculty expectations, program leadership and faculty qualifications and responsibilities, clinical curriculum content guidelines, feedback and evaluation of residents, faculty, and the program, the assignment of a Clinical Competency Committee, physician well-being, and work hours, to name a few.

- Rotation requirements: some clinical domains have requirements in minimum number of patient encounters and/or minimum number of hours or weeks spent on a service
- Learning activities: scholarly activity, quality improvement in addition to didactics
- Milestones: competency-based summative evaluation tool completed twice a year for each resident to demonstrate progression "by residents/fellows from the beginning of their education through graduation to the unsupervised practice

Table 1. Overview of ABFM and ACGME

	American Board of Family Medicine (ABFM)[2]	Accreditation Council of Graduate Medical Education Family Medicine Review Committee (ACGME FM-RC)[3,4]
Primary purpose	Certification of an individual physician	Accreditation of a residency program
Outcomes	Program directors attest residents have met all requirements for board eligibility and are ready for autonomous practice	Program directors complete a web-based accreditation data system report, which is reviewed by ACGME staff and FM-RC to ascertain compliance with program requirements ACGME accreditation field representatives historically* visit for initial and ongoing site reviews **At time of writing these are suspended*
Structure	One of 24 Boards that comprise the American Board of Medical Specialties Governed by a Board of Directors comprised of 16* physician members including the immediate past chair plus 2 public members *11 family physicians and 5 representatives selected from the American Boards of Internal Medicine, Obstetrics/Gynecology, Pediatrics, Psychiatry/Neurology, and Surgery	One of 28 specialty RCs that provide program requirements and resources for residency training Comprised of 14 members including 1 resident and 1 public member
Residency training requirements	Candidates for certification must complete 36 months of graduate medical education (GME) in an ACGME-accredited FM residency program Residents must spend their PGY-2 and PGY-3 training in the same residency program's teaching practice Each year of residency must include a minimum of 40 weeks of continuity clinic experience	ACGME Common Program Requirements, FM Program Requirements* and FAQs currently in effect describing expectations for program administration, aims, curriculum, and resources are found at https://www.acgme.org/specialties/family-medicine/program-requirements-and-faqs-and-applications/ Residents must complete the last 24 months of training at the same family medicine program Residents should provide care within the family medicine practice for a minimum of 40 weeks during each year of training **At time of writing proposed revisions to FM program requirements are in progress.*
Time away from residency & continuity	A resident may take up to 20 weeks of leave over 3 years of residency without requiring an extension of training If a resident's leave exceeds either 12 weeks away from the program in a given year, and/or a maximum of 20 weeks total, then extension of the resident's training may cover the duration of time that the individual was away from the program in excess of 20 weeks	Programs must allow an appropriate length of absence for residents unable to perform patient care responsibilities and may need to extend length of training depending on length of absence and specialty board eligibility requirements Residents should provide care for patients in the FMP site for a minimum of 40 weeks during each year of the program Other assignments should not interrupt continuity for more than 8 weeks at any given time or in any 1 year The periods between interruptions in continuity should be at least 4 weeks in length
Family leave	Allows up to 12 weeks away from the program in a given academic year without requiring an extension of training, as long as the program director and CCC agree that the resident is ready for advancement, and ultimately for autonomous practice A resident must have at least 40 weeks of formal training in the year in which they take family leave	Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities, including for parental leave
Surveys	Administers the National Family Medicine Graduate Survey to all board-certified family physicians 3 years out of residency regarding features of their clinical practice, practice environment and satisfaction with training Data are summarized at the residency-specific level and program-specific reports include comparators at the national level	Resident/fellow and faculty surveys provide early warning of potential non-compliance with ACGME accreditation requirements All accredited programs are required to participate in these surveys each academic year between the months of January and April Data are summarized at the program level and reports include comparators at the national level

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Table 1. Overview of ABFM and ACGME *(continued)*

	American Board of Family Medicine (ABFM)[2]	Accreditation Council of Graduate Medical Education Family Medicine Review Committee (ACGME FM-RC)[3,4]
Milestones	n/a	The ACGME Milestones 2.0 provide a framework for the assessment of the development of the resident in key dimensions of the elements of physician competency in a specialty or subspecialty
Osteopathic considerations	Graduates of an American Osteopathic Association (AOA)-approved medical school may qualify for certification by completing 36 months of ACGME-accredited family medicine residency training OR by applying through the AOA Training Pathway (entry limited through December 31, 2022)	Residencies may apply for Osteopathic Recognition (OR) ACGME OR program requirements and FAQs in effect are available at https://www.acgme.org/specialties/osteopathic-neuromusculoskeletal-medicine/overview/ Recognition field representatives historically* visit for initial and ongoing accreditation status **At time of writing these are suspended*
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of their specialties." They neither represent the entirety of the dimensions of the 6 domains of physician competency, nor are they designed to be relevant in any other context, including program accreditation or final determination of a resident's graduation from residency.

- Annual faculty and resident surveys: online surveys distributed to all residents and faculty that are used to obtain feedback on the residency program and guide future program improvement efforts as part of the annual program evaluation. The required completion rate for both the resident/fellow and faculty survey is 70%. Programs failing to meet this threshold will not receive reports. When programs meet the required completion rate, and there are 4 or more people scheduled to participate in a survey, aggregated and anonymized survey data reports will be available. Programs that do not reach the 70% response threshold flag as noncompliant and are highlighted as such for the review committees, which may take further action.
- Annual program evaluation (APE): mandatory report to ACGME that provides a "snapshot" of the residency program, including summary of each resident, report on scholarly activity completed by residents and core faculty, and program improvement plan to address areas of growth identified in the annual faculty and resident surveys. This information is submitted to ACGME via the accreditation data system.
- Accreditation data system (ADS or WebADS): data collection system to collect, organize, and maintain information for accreditation and recognition purposes. Information about program, residents, graduates, faculty, and curriculum is updated annually in ADS as part of the annual program evaluation
- Self-study: "an objective, comprehensive evaluation of the residency or fellowship program" that uses the results of sequential annual program evaluation results to assess efforts to improve the program over time
- Site visits, either in person or virtual, are conducted by the ACGME as part of the accreditation process to assess compliance with institutional and program requirements. Site visits typically include interviews with program leadership and residents.

Meeting the objectives of the ABFM and ACGME is but one aspect of program directors' and assistant/associate program directors' job duties. Table 1 provides an overview of the 2 organizations. The variety of family medicine program types, settings, and structures make it difficult for 1 resource to meet the needs of all program directors when questions arise. It is vital to have a community of peers to whom one can pose questions, receive feedback, and ask questions in the ever-changing world of graduate medical education. One such resource is the Association of Family Medicine Residency

Directors (AFMRD), which provides a number of resources to program leadership, such as the PD Toolbox and Resource Library, in addition to an active, collaborative online community where members can pose questions and benefit from the expertise of fellow program directors across the country. Directors of osteopathic education may use the American Osteopathic Board of Family Physicians website as a resource for designated osteopathic residents desiring AOA board certification in Family Medicine.

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AAFP From the American Academy of Family Physicians

Ann Fam Med 2022;20:185-186. https://doi.org/10.1370/afm.2806

FROM AAFP: AAFP ADVANCES ON LONG-TERM CLINICAL RECOMMENDATION PROJECT

The AAFP has taken the next steps toward a project designed to make it easier for family physicians to access, review, and share the clinical guidelines and related information that help them give patients optimal care, in resources available at https://www.aafp.org/family-physician/patient-care/clinical-recommendations.html.

After launching the project with development of a chronic obstructive pulmonary disease (COPD) clinical guidance webpage, the Academy recently published a new clinical guidance page on diabetes that lets members find clinical recommendations, implementation tools, quality measures, and educational materials for physicians in 1 location.

Diabetes: Clinical Guidance and Practice Resources at a Glance

The new clinical guidance page organizes information into several categories.

- **Screening Recommendations** contains a link to the updated AAFP clinical preventive service recommendations
- **Treatment and Management Recommendations** features links to AAFP-endorsed or supported guidance on oral pharmacologic treatment and the care of people who have or are at risk of having diabetes
- **Managing Your Practice** gives members an assortment of tools and resources to better coordinate and improve patient care
- **Implementation Tools and Considerations** links to a report on diabetes self-management education and support co-authored by the Academy and 6 other medical organizations, as well as links to 3 AAFP TIPS activities
- **Education** provides CME resources for clinicians, links to articles on diabetes and a series of patient education materials on familydoctor.org
- **Other Related Resources** directs members to the Academy's Prevention and Wellness: Healthy Lifestyle webpage, which features information on nutrition and physical activity, oral health and related topics

The highlight of the page is "Diabetes Screening for Adults," an updated clinical recommendation developed by the AAFP and approved in November 2021.

The AAFP's recommendation is based on a final recommendation statement on screening for prediabetes and type 2 diabetes published by the US Preventive Services Task Force in August 2021.

It should be noted that the AAFP's recommendation differs from the task force's recommendation statement in some areas.

The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity, and also recommends that clinicians offer or refer patients with prediabetes to effective preventive interventions. In contrast, the AAFP has concluded that the evidence is insufficient to assess the benefits and harms of screening for type 2 diabetes in adults aged 35 to 39 years. The AAFP stated in its recommendation that most of the evidence presented in the task force's evidence report looked at adults over age 40, and that there were no subgroup analyses that specifically examined screening at younger ages.

Moreover, the AAFP does not agree that there is evidence to support screening for prediabetes. In its recommendation, the AAFP stated that "the current evidence does not show improvement in long-term health outcomes for screening for prediabetes in adults who have obesity or overweight," and that since screening for prediabetes is neither sensitive nor specific, it may result in false positives or false negatives.

Sarah Coles, MD, chair of the Academy's Commission on Health of the Public and Science and an assistant professor in the Department of Family, Community and Preventive Medicine at the University of Arizona College of Medicine–Phoenix Family Medicine Residency, told *AAFP News* why the Academy's stance differed from that of the task force.

"The AAFP agrees with screening for diabetes in adults ages 40 to 70 who have obesity or are overweight and screening pregnant persons for gestational diabetes at 24 weeks gestation or greater," said Coles. "After careful review of the USPSTF evidence report, the AAFP disagreed with the USPSTF on a few key points.